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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **AMBER MARIE FORTENBERRY** **815 N. Mollison Avenue, Apt. 32** **El Cajon, CA 92021** **Registered Nurse License No. 733331** Respondent.	Case No. 2013-416 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about July 31, 2008, the Board of Registered Nursing issued Registered Nurse License Number 733331 to Amber Marie Fortenberry (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein, expired on September 30, 2011, and has not been renewed.

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Business and Professions Code (Code) provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811(b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY PROVISIONS

6. Section 2761(a) of the Code provides that the board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for unprofessional conduct.

7. Section 2762 of the Code states:

> In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:
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> (a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.
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> (b) Use any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.
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> . . .
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> (e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

COST RECOVERY

8. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

DRUGS

9. Methamphetamine is a Schedule II controlled substance as designated by Health and Safety Code section 11055(d)(2), and is a dangerous drug pursuant to Code section 4022.

10. Dilaudid, a brand name for hydromorphone, is a Schedule II controlled substance as designated by Health and Safety Code section 11055(b)(1)(J), and is a dangerous drug pursuant to Code section 4022.

11. Ambien, a brand name for zolpidem tartrate, is a schedule IV controlled substance as designated by Health and Safety Code section 11057(d)(32), and is a dangerous drug pursuant to Code section 4022.

FACTS

12. Respondent was employed as a registered nurse at Vibra Hospital of San Diego (VHSD) from November 2, 2010, through January 26, 2011.

13. On or about January 17, 2011, Respondent, by her own admission, self administered the controlled substance methamphetamine while she knew she was scheduled to work as a registered nurse at VHSD on the next day, January 18, 2011.

14. On January 18, 2011, Respondent was scheduled to work as a registered nurse at VHSD during the "night-shift" from 6:30 p.m. to 7:00 a.m. but, Respondent reported for work late and sometime after 6:30 p.m. At the beginning of Respondent's shift, her co worker, "Nurse A", noticed that Respondent' behavior was unusual in that she seemed distracted and uncomfortable, she was constantly squinting and she often made loud sighing noises while sitting at the nurses station. Nurse A asked Respondent if she was "o.k?" Respondent replied that she had a headache caused by a unique medical condition with which she has been diagnosed.

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15. At or about 7:30 p.m. on January 18, 2011, another co-worker of Respondent, Nurse B, noticed that Respondent was acting odd in that her speech was slurred, her behavior seemed hyperactive, she frequently scratched her arms and face, her appearance was messy, and she "looked high." Nurse B was concerned for patient safety due to Respondent's odd behavior and reported Respondent's odd behavior to the charge nurse.

16. At or about 9:00 p.m. on January 18, 2011, Respondent was manually counting and documenting all medications securely stored inside the Med-Dispense machine[1], pursuant to VHSD policy. Nurse A observed Respondent attempting to complete this basic task and noticed that Respondent was having extraordinary difficulty counting the pills. Nurse A offered to help Respondent to complete the manual count. Nurse A manually counted 25 Dilaudid 4mg tablets in the Med-Dispense cassette and then he also saw three more Dilaudid 4mg tablets in Respondent's hand. Nurse A asked Respondent about the three Dilaudid 4 mg tablets in her hand and Respondent replied that all three should be added to the 25 Dilaudid 4mg counted in the cassette and should be included in Nurse A's manual count of the Dilaudid 4mg tablets in the Med-Dispense. Therefore, the Med-Dispense manual count for Dilaudid 4mg was 28 tablets at approximately 9:00 p.m. on January 18, 2011.

17. On January 18, 2011, at approximately 9:12 p.m., Respondent accessed the Med-Dispense machine for the purpose of withdrawing one Dilaudid 4mg tablet for administration to Patient 1. In accordance with VHSD policy, Respondent documented that she manually counted 28 Dilaudid 4 mg tablets in the Med-Dispense cassette before she removed any Dilaudid for Patient 1. The Med-Dispense machine indicated that there were 28 Dilaudid 4mg tablets in the machine. Respondent documented that she removed one Dilaudid 4mg tablet from the Med-Dispense machine for the purpose of administration to Patient 1. Thereafter, on January 18, 2011,

[1] "Med-Dispense" is an automated medication dispensing system that records information such as patient name, physician orders, date and time medication was withdrawn, and the name of the licensed individual who withdrew the medication for administration to a patient. Each user/operator is given a "user ID" code to operate the control panel. The user is required to enter a second code "PIN" number, similar to an ATM machine, to gain access to the medications. Any portion of dispensed medication that is not administered to the patient is referred to as wastage. This wastage must be witnessed by another authorized user and is also recorded by the Med-Dispense machine.

at approximately 9:12 pm, the Med-Dispense machine indicated that there were 27 Dilaudid 4 mg tablets inside the machine.

18. Respondent did not document or otherwise account for what she did with the one Dilaudid 4mg tablet that she removed from the Med-Dispense machine and signed out at approximately 9:12 p.m. on January 18, 2011. Respondent did not document administration of the Dilaudid 4mg tablet to Patient 1 in the patient's record, the Medication Administration Record (MAR), or anywhere else. Respondent did not document wastage of the Dilaudid 4mg tablet. The MAR verification form for Patient 1 on January 18, 2011, indicated that Patient 1 did not receive a Dilaudid 4mg tablet during the afternoon shift between 3:00 and 11:00 p.m. on January 18, 2011, in that there was a circle , but no initials next to the 6:00 p.m. notation regarding scheduled administration of the Dilaudid; the MAR itself shows crossed out initials next to the 11:00 p.m. administration of Dilaudid to Patient 1 and there is no verification signature on the MAR as required by VHSD policy for verification of the crossed out initials on the MAR. Respondent failed to account for the Dilaudid 4mg tablet.

19. On January 18, 2011, at approximately 9:12 p.m., Respondent documented that she also removed two Ambien 5mg tablets from the Med-Dispense machine for administration to Patient 1. Respondent did not document or otherwise account for what she did with those two Ambien 5mg tablets. Respondent did not document administration of any Ambien 5mg tablets to Patient 1 in the patient's record for January 8, 2011, the MAR, or anywhere else. Respondent did not document wastage of the two Ambien 5mg tablets. The MAR verification form for Patient 1 on January 18, 2011, indicated that Patient 1 did not receive any Ambien 5mg tablets from Respondent on January 18, 2011. Respondent failed to account for the two Ambien 5mg tablets.

20. On January 18, 2011, at approximately 9:30 pm, Respondent requested to leave work unexpectedly early due to illness. Respondent's request was granted and she promptly left the hospital. Nurse C took over Respondent's professional duties and provided care for all of the patients that were previously assigned to Respondent during the night-shift on January 18, 2011.

21. On January 18, 2011, at approximately 10:41 p.m., Nurse C was the next person to access the Dilaudid 4mg tablets in the Med-Dispense machine since 9:12 p.m. when Respondent

documented that she accessed the Dilaudid 4mg and removed one Dilaudid 4mg tablet from the Med-Dispense machine, as described, above, in paragraph 16. Pursuant to VHSD policy, Nurse C manually counted the Dilaudid 4mg tablets inside the Med-Dispense machine before she documented the removal of any Dilaudid 4mg from the machine. At approximately 10:41 pm. Nurse C manually counted only 25 Dilaudid 4mg tablets inside the Med-Dispense machine. However, the Med-Dispense machine indicated that there were 27 Dilaudid 4 mg tablets inside (the machine) at that time. Two Dilaudid 4 mg tablets had been removed without documentation at between after 9:12 p.m. when Respondent accessed the Dilaudid 4 mg tablets in the Med-Dispense machine and documented that she removed one Dilaudid 4mg tablet, and before 10:41 p.m. when Nurse C accessed the Dilaudid 4mg tablets in the Med-Dispense machine and manually counted only 25 Dilaudid 4 mg tablets inside the machine. Nurse C promptly reported the missing 2 Dilaudid 4mg tablets to the charge nurse. Respondent had already stopped working and left the hospital by the time Nurse C discovered that there were 2 Dilaudid 4mg tablets missing from the Med-Dispense machine and that Respondent was the last person to access the Dilaudid 4mg tablets in the Med-Dispense machine soon before Respondent reported feeling ill and leaving the hospital.

22. Respondent's handwritten notes on January 18, 2011, in Patient 1's medical records, including her handwritten nurse narrative notes on the medical/surgical flow-sheet, were unintelligible, sloppy, and illegible. Respondent's handwritten notes in Patient 1's medical records on January 18, 2011, did not provide any useful information regarding whether Respondent had administered any Dilaudid or Ambien to the patient after Respondent had signed out the medications from the Med-Dispense machine for the stated purpose of administration to Patient 1.

23. On or about January 19, 2011, at approximately 8:20 am, Respondent called VHSD and agreed to come to VHSD for a conference at 10:00 a.m. to discuss the Dilaudid and Ambien that was unaccounted for since Respondent's last work shift on January 18, 2012. Respondent failed to appear for the conference at the designated time and place. Respondent did not call or contact anyone to inform them that she would be late or otherwise unable to attend the pre-

arranged conference. At approximately 11:00 a.m. Respondent called VHSD and stated that she could not come in for a conference that day due to a prior family commitment. VHSD then notified Respondent that she was on investigative suspension effective immediately, January 19, 2011, for reasonable suspicion of narcotic diversion and that VHSD needed Respondent to come in for a conference to discuss the matter as soon as she was able.

24. On January 19, 2011, Respondent came to VHSD and provided a urine sample for drug testing purposes at approximately 7:00 p.m. On January 25, 2011, the urine sample analysis indicated that Respondent tested positive for amphetamine and methamphetamine.

25. On January 26, 2011, Respondent came to VHSD and participated in a conference with several supervising staff members. Respondent stated that she did not remember any specific events that occurred while she was working as a registered nurse on the night of January 18, 2011. Respondent stated that she does not remember removing, taking, or administering any Dilaudid or Ambien for any patient on January 18, 2011. Respondent admitted that she was under the influence of a drug while she was working as a registered nurse on January 18, 2011, and stated that she had obtained the drug from outside the hospital. Respondent stated that she was not able to safely work as a registered nurse or care for patients while she was under the influence of the drug during her shift on January 18, 2011, and that is the true reason that she reported feeling ill and requested to stop working and leave the hospital early on January 18, 2011. Respondent's employment at VHSD was then terminated.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

26. Respondent is subject to disciplinary action under Code section 2761(a) in that she acted unprofessionally as described, above, in paragraphs 12 through 25 which are incorporated herein by reference.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Unlawful Use of Controlled Substance)

27. Respondent is subject to disciplinary action under Code section 2762, subdivision (b) in that Respondent unlawfully self-administered the controlled substance methamphetamine on or

about January 17, 2011, as described, above, in paragraphs 12 through 25 which are incorporated herein by reference.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Worked as a Registered Nurse While Impaired and Under the Influence of a Drug)

28. Respondent is subject to disciplinary action under Code section 2762, subdivision (b) in that Respondent reported for work and worked as a registered nurse while she was impaired, under the influence of a drug, and unable to safely care for her patients on or about January 18, 2011, as described, above, in paragraphs 12 through 25 which are incorporated herein by reference.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct - False, Incorrect, Inconsistent or Unintelligible Charting)

29. Respondent is subject to disciplinary action under Code section 2762(e) in that she falsified, or made grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to controlled substances/dangerous drugs, as described, above, in paragraphs 12 through 25 which are incorporated herein by reference.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 733331, issued to Amber Marie Fortenberry

2. Ordering Amber Marie Fortenberry to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

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3. Taking such other and further action as deemed necessary and proper.

DATED: November 21, 2012

LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

SD2012703864